

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services hereby gives Notice of Intended Action to amend Chapter 77, “Conditions of Participation for Providers of Medical and Remedial Care,” Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services,” and Chapter 83, “Medicaid Waiver Services,” Iowa Administrative Code.

Iowa’s Medicaid program is evolving to create a single system of care to address the health care needs of the whole person, including the physical health, behavioral health, and long-term care services and supports. The purposes of these proposed amendments are to deliver quality, patient-centered care and to create efficiencies. On April 1, 2016, the majority of Medicaid members began having their services coordinated through managed care organizations (MCOs). Members in the following programs are not included in this transition: the Health Insurance Premium Payment (HIPP) Program, programs for the medically needy, and programs for all-inclusive care for the elderly (PACE) enrollees, as well as members who are American Indian or Alaskan natives, or those who participate in the Medicare Savings Program.

These proposed amendments are intended to implement changes related to managed care and provide technical clarification. Changes include:

- Replacing references to “service worker” with references to “designated case manager” as members of the AIDS/HIV, health and disability (H&D) and physical disability (PD) waivers will have community-based case managers through their MCOs or through fee-for-service Medicaid.
- Replacing outdated references to “Case Management Comprehensive Assessment” under the brain injury (BI), elderly, and children’s mental health (CMH) waivers with references to a department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub.L. No. 111-148) to enable MCOs and Iowa Medicaid Enterprise (IME) to utilize the interRAI assessment tool or another department-approved standardized assessment tool for level of care determinations for the six home- and community-based services (HCBS) waiver programs and the needs-based eligibility determinations for the HCBS habilitation program.
- Replacing outdated references to “service worker assessment” under the AIDS/HIV, H&D and PD waivers with references to Form 470-4694 for children under the age of four and, for all others, a department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148) to enable MCOs and IME to utilize the interRAI assessment tool or another department-approved standardized assessment tool.
- Adding completion of Form 470-4694 for children under the age of five for the intellectual disability waiver.
- Adding three diagnoses for brain injury: cerebral edema, cerebral palsy, and status epilepticus.
- Adding definitions for “integrated health home” and “care coordinator” to the CMH waiver.

The Department implemented the IA Health Link Program on April 1, 2016. The majority of HCBS waiver members receive comprehensive care coordination through an MCO.

For state fiscal year 2017, funds were appropriated to be used to support the development and implementation of standardized assessment tools for persons with mental illness, an intellectual disability, a developmental disability, or a brain injury.

These proposed amendments allow for use of Form 470-4694 for children under the age of four and, for all others, the interRAI assessment tool in the AIDS/HIV, BI, CMH, elderly, H&D and PD waiver programs and the HCBS habilitation program, bringing the Department's rules into compliance with the 2013 legislative mandate, the recommendations of the redesign stakeholder groups, current practice, and Iowa's Balancing Incentive Program application.

Authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), the Balancing Incentive Program provides enhanced Federal Medical Assistance Percentages (FMAP) to states that spend less than 50 percent of long-term care dollars on care provided in home- and community-based settings. To qualify for these funds, states must implement three structural changes in their systems of community-based long-term services and supports (LTSS): a no wrong door/single entry point (NWD/SEP) eligibility determination and enrollment system; core standardized assessment instruments; and conflict-free case management. The Balancing Incentive Program requires the following of participating states: "development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs."

The IME and MCOs will use Form 470-4694 for children under the age of four and, for all others, the interRAI assessment tool for initial and annual assessments. The interRAI is a nationally recognized assessment tool that was developed for use with adults in home- and community-based settings. The instrument is generally used with the frail elderly or persons with disabilities who are seeking or receiving formal health care and supportive services. The interRAI was first developed in 1994. Initially, it was designed to be compatible with the long-term care facilities system and was implemented in nursing homes.

The decision to use the interRAI was highly vetted by the Department. The development, selection, and use of a core standardized assessment (CSA) were part of the Balancing Incentive Program in Iowa. The CSA selection process started in May 2015, with statewide Webinars and in-person listening and learning sessions designed to seek input from members, advocates, providers, and case managers. These listening and learning sessions were used to educate and inform individuals about various CSAs. After reviewing feedback and comments from the sessions, the Department selected the interRAI assessment tool for use with HCBS waiver and habilitation program members. The interRAI best matched the core domains of the Balancing Incentive Program criteria and included superior inter-rater reliability.

Any interested person may make written comments on the proposed amendments on or before February 21, 2017. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

The following amendments are proposed.

ITEM 1. Amend subrule 77.25(5) as follows:

77.25(5) Case management. ~~The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is~~ A provider is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in if accredited as a case management provider pursuant to 441—Chapter 24.

ITEM 2. Amend subrule 77.29(1) as follows:

77.29(1) Standards in 441—Chapter 24. ~~Providers shall meet the standards in~~ be accredited as case management providers pursuant to 441—Chapter 24 ~~when they are the department of human services,~~

~~a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties as a condition of providing case management services to persons with mental retardation~~ an intellectual disability, developmental disabilities or chronic mental illness.

ITEM 3. Amend paragraph **78.27(2)“d”** as follows:

~~d. Needs assessment. The member’s case manager or integrated health home care coordinator has completed an assessment of the member’s need for service, and A department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148) has been completed, and based on that assessment, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The designated case manager or integrated health home care coordinator shall:~~

~~(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before~~ Before services begin and annually thereafter, arrange for the completion of a department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).

~~(2) Use~~ Before services begin and annually thereafter, use the evaluation assessment results to develop a comprehensive service plan as specified in subrule 78.27(4).

ITEM 4. Amend paragraph **83.2(1)“d”** as follows:

~~d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program a completed Form 470-4694 for children under the age of four and, for all others, a department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).~~

~~(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care. The member’s designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in rule 441—90.5(249A).~~

~~(2) to (4) No change.~~

ITEM 5. Amend paragraph **83.2(2)“a”** as follows:

~~a. The member shall have a service plan approved by the department which is developed by the service worker or targeted designated case manager identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.~~

~~The service worker or targeted designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member’s need for service based on the member’s needs and desires as well as the availability and appropriateness of services, using the following criteria:~~

~~(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 a completed Form 470-4694 for children under the age of four and, for all others, a department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), which shall be completed annually. The service worker or targeted designated case manager shall have a face-to-face visit with the member at least annually quarterly.~~

~~(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker or targeted designated case manager shall list all nonwaiver Medicaid services in the service plan.~~

~~(3) No change.~~

ITEM 6. Amend paragraph **83.3(3)“a”** as follows:

~~a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:~~

~~(1) to (3) No change.~~

(4) The application is pending because a level of care determination has not been made although the ~~completed Form 470-4392, Level of Care Certification for HCBS Waiver Program~~, required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment, ~~Form 470-4392, or the service plan~~ has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, ~~Form 470-4392, or service plan~~, the application shall be denied.

ITEM 7. Amend paragraph **83.3(3)“c”** as follows:

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign ~~Form 470-5044, Service Worker Comprehensive Assessment~~, the assessment and indicate that the applicant has elected home- and community-based services.

ITEM 8. Amend paragraph **83.8(2)“d”** as follows:

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the ~~service worker or targeted~~ designated case manager.

ITEM 9. Amend paragraph **83.22(1)“d,”** introductory paragraph, as follows:

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program~~ the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).

ITEM 10. Amend subparagraph **83.22(1)“d”(1)** as follows:

(1) ~~A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392~~ The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

ITEM 11. Amend paragraph **83.22(2)“a”** as follows:

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to ~~441—subrule 77.33(21)~~ rule 441—77.29(249A). Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~.

ITEM 12. Amend paragraph **83.23(3)“c”** as follows:

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign ~~Form 470-4694, Case Management Comprehensive Assessment~~ the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), indicating that the applicant has elected waiver services.

ITEM 13. Amend paragraph **83.42(1)“b”** as follows:

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based on information submitted on ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program~~ a completed Form 470-4694 for children under the age of four and, for all others, the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).

(1) ~~A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392~~ Form 470-4694 for children under the age of four and, for all others, the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148) shall be

completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care.

(2) and (3) No change.

ITEM 14. Amend paragraph **83.42(2)“a”** as follows:

a. The ~~department service worker~~ designated case manager shall ~~perform an~~ review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This ~~assessment~~ review shall be based, in part, on information in the completed ~~Service Worker Comprehensive Assessment, Form 470-5044~~ Form 470-4694 for children under the age of four and, for all others, the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148). ~~Form 470-5044 shall be completed annually.~~

ITEM 15. Amend subparagraph **83.43(3)“a”(2)** as follows:

(2) The application is pending because a level of care determination has not been made although the completed ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program,~~ assessment has been submitted to the IME medical services unit.

ITEM 16. Amend paragraph **83.43(3)“c”** as follows:

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign ~~Form 470-5044, Service Worker Comprehensive Assessment,~~ the assessment and indicate that the applicant has elected home- and community-based services.

ITEM 17. Amend paragraph **83.61(2)“a”** as follows:

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, an SIS assessment.

ITEM 18. Amend subparagraph **83.61(2)“b”(1)** as follows:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, an SIS assessment for the initial level of care determination;

ITEM 19. Amend paragraph **83.61(2)“f”** as follows:

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange an SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the ~~worker~~ case manager can document difficulty in locating information necessary to arrange the SIS assessment or other circumstances beyond the ~~worker's~~ case manager's control.

ITEM 20. Amend subparagraph **83.61(2)“g”(1)** as follows:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor's off-year review.

ITEM 21. Amend rule 441—83.64(249A) as follows:

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) and 83.64(2) No change.

ITEM 22. Amend rule **441—83.81(249A)**, definition of “Brain injury,” as follows:

“*Brain injury*” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.
- Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
- Malignant neoplasms of brain, cerebral meninges.
- Malignant neoplasms of brain, cranial nerves.
- Secondary malignant neoplasm of brain.
- Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
- Benign neoplasm of brain and other parts of the nervous system, brain.
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
- Encephalitis, myelitis and encephalomyelitis.
- Intracranial and intraspinal abscess.
- Anoxic brain damage.
- Subarachnoid hemorrhage.
- Intracerebral hemorrhage.
- Other and unspecified intracranial hemorrhage.
- Occlusion and stenosis of precerebral arteries.
- Occlusion of cerebral arteries.
- Transient cerebral ischemia.
- Acute, but ill-defined, cerebrovascular disease.
- Other and ill-defined cerebrovascular diseases.
- Fracture of vault of skull.
- Fracture of base of skull.
- Other and unqualified skull fractures.
- Multiple fractures involving skull or face with other bones.
- Concussion.
- Cerebral laceration and contusion.
- Cerebral edema
- Cerebral palsy.
- Subarachnoid, subdural, and extradural hemorrhage following injury.
- Other and unspecified intracranial hemorrhage following injury.
- Intracranial injury of other and unspecified nature.
- Poisoning by drugs, medicinal and biological substances.
- Toxic effects of substances.
- Effects of external causes.
- Drowning and nonfatal submersion.
- Asphyxiation and strangulation.
- Child maltreatment syndrome.
- Adult maltreatment syndrome.
- Status epilepticus.

ITEM 23. Amend paragraph **83.83(2)“c”** as follows:

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall ~~complete and sign Form 470-4694, Case Management Comprehensive Assessment~~ the assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

ITEM 24. Amend paragraph **83.83(2)“d”** as follows:

d. The medical facility discharge planner, if there is one involved, shall contact the ~~appropriate case manager for the consumer’s county of residence~~ managed care organization or the designated case manager to initiate development of the consumer’s service plan and initiation of waiver services.

ITEM 25. Amend subrule 83.87(3) as follows:

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member’s need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed ~~Form 470-4694, Case Management Comprehensive Assessment~~, assessment and supporting documentation as needed.

a. and b. No change.

ITEM 26. Amend paragraph **83.102(1)“h”** as follows:

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program~~ the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).

~~(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.~~

~~(2)~~ (1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

~~(3)~~ (2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

ITEM 27. Amend subparagraph **83.102(2)“a”(1)** as follows:

(1) The ~~service worker~~ designated case manager shall identify the need for service based on the needs of the applicant, as documented in ~~Form 470-5044, Service Worker Comprehensive Assessment in the assessment~~, as well as the availability and appropriateness of services.

ITEM 28. Amend subrule 83.103(2) as follows:

83.103(2) Approval of application for eligibility.

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant’s consent or with the consent of the applicant’s legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall ~~have the applicant’s primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit~~ contact the member’s managed care organization or designated case manager to arrange for completion of the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).

(2) No change.

b. Applications for this waiver shall be initiated by the applicant, the applicant’s parent or legal guardian, or the applicant’s attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's ~~primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program,~~ managed care organization or the designated case manager shall arrange for the completion of the assessment and submit it to the IME medical services unit.

(2) No change.

c. No change.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign ~~Form 470-5044, Service Worker Comprehensive Assessment~~ the assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the ~~service worker or~~ designated case manager in the development of the service plan prior to the start of services.

f. and g. No change.

ITEM 29. Amend rule 441—83.107(249A), introductory paragraph, as follows:

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the ~~DHS service worker~~ designated case manager prior to services beginning and payment being made to the provider. ~~The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.~~

ITEM 30. Amend subrule 83.107(2) as follows:

83.107(2) Annual assessment. The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the completed ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program,~~ department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148) and on supporting documentation as needed.

a. and b. No change.

ITEM 31. Adopt the following new definitions of "Care coordinator" and "Integrated health home" in rule **441—83.121(249A)**:

"*Care coordinator*" means the professional who assists members in care coordination as described in 441—paragraph 78.53(1) "b."

"*Integrated health home*" means the provision of services to enrolled members as described in 441—subrule 78.53(1).

ITEM 32. Amend subrule 83.122(3) as follows:

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on ~~Form 470-4694, Case Management Comprehensive Assessment for children under the age of four and, for all others, the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).~~

ITEM 33. Amend subrule 83.122(5) as follows:

83.122(5) Choice of program. The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on ~~Form 470-4694, Case Management Comprehensive Assessment~~ the assessment.

ITEM 34. Amend paragraph **83.122(6)“a”** as follows:

a. The consumer must be a recipient of ~~targeted~~ case management or integrated health home services or be identified to receive ~~targeted~~ case management or integrated health home services immediately following program enrollment.

ITEM 35. Amend paragraph **83.123(1)“a”** as follows:

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or

(2) ~~Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member’s parent or legal guardian; or~~

(3) (2) A written request signed and dated by a Medicaid member’s parent or legal guardian.

ITEM 36. Amend rule 441—83.127(249A), introductory paragraph, as follows:

441—83.127(249A) Service plan. The consumer’s case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

ITEM 37. Amend subrule 83.127(3) as follows:

83.127(3) The service plan shall be based on information in Form 470-4694, ~~Case Management Comprehensive Assessment~~ for children under the age of four and, for all others, the department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).

ITEM 38. Amend paragraph **83.128(2)“d”** as follows:

d. The physical or mental condition of the consumer requires more care than can be provided in the consumer’s own home, as determined by the consumer’s case manager or integrated health home care coordinator.